

Facility Name & ID Number St Francis Nursing & Rehab Center# 0044370 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>78</u>	Skilled (SNF)	<u>78</u>	<u>28,470</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>46</u>	Intermediate (ICF)	<u>46</u>	<u>16,790</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>124</u>	TOTALS	<u>124</u>	<u>45,260</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,232</u>	<u>4,335</u>	<u>6,698</u>	<u>20,265</u>	8
9	SNF/PED					9
10	ICF	<u>9,717</u>	<u>2,655</u>	<u>446</u>	<u>12,818</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,949</u>	<u>6,990</u>	<u>7,144</u>	<u>33,083</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.10%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/08/85

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 03/08/85 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 20 and days of care provided 5,844Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning: 07/01/02

Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	292,143	23,487	9,650	325,280		325,280		325,280			1
2	Food Purchase		188,406		188,406		188,406	(2,453)	185,953			2
3	Housekeeping	143,409	16,854	29,046	189,309	(3,530)	185,779		185,779			3
4	Laundry	8,859		113,092	121,951		121,951		121,951			4
5	Heat and Other Utilities			112,241	112,241		112,241		112,241			5
6	Maintenance		10,761	45,556	56,317	30,878	87,195		87,195			6
7	Other (specify):*											7
8	TOTAL General Services	444,411	239,508	309,585	993,504	27,348	1,020,852	(2,453)	1,018,399			8
	B. Health Care and Programs											
9	Medical Director			16,888	16,888	(3,760)	13,128		13,128			9
10	Nursing and Medical Records	1,783,076	40,780	126,499	1,950,355	84,449	2,034,804		2,034,804			10
10a	Therapy	255,054	1,467	32,157	288,678	168	288,846		288,846			10a
11	Activities	52,452	1,107	6,306	59,865	3,362	63,227		63,227			11
12	Social Services	83,206	257	1,131	84,594		84,594		84,594			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,173,788	43,611	182,981	2,400,380	84,219	2,484,599		2,484,599			16
	C. General Administration											
17	Administrative	96,027		603,321	699,348		699,348		699,348			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			15,439	15,439	566	16,005		16,005			20
21	Clerical & General Office Expenses	174,517	8,915	65,898	249,330	(111,567)	137,763		137,763			21
22	Employee Benefits & Payroll Taxes			810,985	810,985		810,985		810,985			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,298	5,298	(1,048)	4,250		4,250			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			134,579	134,579		134,579		134,579			26
27	Other (specify):*											27
28	TOTAL General Administration	270,544	8,915	1,635,520	1,914,979	(112,049)	1,802,930		1,802,930			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,888,743	292,034	2,128,086	5,308,863	(482)	5,308,381	(2,453)	5,305,928			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			423,673	423,673		423,673		423,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,287	29,287		29,287		29,287			35
36	Other (specify):*											36
37	TOTAL Ownership			452,960	452,960		452,960		452,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,294	8,294	482	8,776		8,776			38
39	Ancillary Service Centers		721,963		721,963	(1,828)	720,135		720,135			39
40	Barber and Beauty Shops					1,828	1,828		1,828			40
41	Coffee and Gift Shops			271	271		271		271			41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):*			28,820	28,820		28,820		28,820			43
44	TOTAL Special Cost Centers		721,963	105,275	827,238	482	827,720		827,720			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,888,743	1,013,997	2,686,321	6,589,061		6,589,061	(2,453)	6,586,608			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number St Francis Nursing & Rehab Center# 0044370

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,453)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,453)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,453)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

St Francis Nursing & Rehab Center

ID# 0044370

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

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Summary A

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning:

07/01/02

Ending:

06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,453)	0	0	0	0	0	0	0	0	0	0	(2,453)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,453)	0	0	0	0	0	0	0	0	0	0	(2,453)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,453)	0	0	0	0	0	0	0	0	0	0	(2,453)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care Corp.	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	17	Management Fee	\$ 603,321	Resurrection Health Care Corp.	100.00%	\$ 603,321	\$ *	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 603,321			\$ 603,321	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Resurrection Health Care Corp.
 Street Address 7435 W. Talcott Ave.
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Corporate Depreciation	Direct Cost	1,026,252,212	25	\$ 13,962,925	\$	5,985,740	\$ 81,440	1
2	17 Corporate Rent	Direct Cost	1,026,252,212	25	1,322,848		5,985,740	7,716	2
3	17 Corporate Insurance	Direct Cost	1,026,252,212	25	69,983		5,985,740	408	3
4	17 Human Resources	Direct Cost	1,026,252,212	25	10,221,435	4,248,748	5,985,740	59,618	4
5	17 Learning & Information Ctr	Direct Cost	1,026,252,212	25	1,460,960	557,503	5,985,740	8,521	5
6	17 Marketing/Public Relations	Direct Cost	1,026,252,212	25	7,801,753	1,998,684	5,985,740	45,505	6
7	17 RHCC Administration	Direct Cost	1,026,252,212	25	11,088,109	4,306,219	5,985,740	64,673	7
8	17 Mission Effectiveness	Direct Cost	1,026,252,212	25	759,000	528,474	5,985,740	4,427	8
9	17 Facilities Management	Direct Cost	1,026,252,212	25	298,772	281,083	5,985,740	1,743	9
10	17 Senior Services Admn	Direct Cost	1,026,252,212	25	791,000	528,650	5,985,740	4,614	10
11	17 Finance Admn & Accounting	Direct Cost	1,026,252,212	25	21,980,217	14,629,155	5,985,740	128,202	11
12	17 Info Svc/Data Processing	Direct Cost	1,026,252,212	25	26,797,279	11,241,242	5,985,740	156,298	12
13	17 Purchasing/Materiels Mgmt	Direct Cost	1,026,252,212	25	5,175,420	4,522,964	5,985,740	30,186	13
14	17 Risk Management	Direct Cost	1,026,252,212	25	892,767	563,532	5,985,740	5,207	14
15	17 Employee Health	Direct Cost	1,026,252,212	25	816,624	737,874	5,985,740	4,763	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 103,439,092	\$ 44,144,128		\$ 603,321	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **St Francis Nursing & Rehab Center**# **0044370** Report Period Beginning: **07/01/02** Ending: **06/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Francis Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044370

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A.

Square Feet:

51,712

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

3

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facility		1985	\$ 188,421	1
2					2
3	TOTALS			\$ 188,421	3

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning:

07/01/02

Ending:

06/30/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	124		1985	1961	\$ 2,426,118	\$ 80,660	30	\$ 80,660	\$	\$ 1,498,534	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	General Construction/Renovation		1986		12,875		12			12,875	9
10	General Construction/Renovation		1986		3,543		10			3,543	10
11	General Construction/Renovation		1986		82,489		15			82,489	11
12	General Construction/Renovation		1986		44,717	2,236	20	2,236		38,985	12
13	General Construction/Renovation		1987		5,529		12			5,529	13
14	General Construction/Renovation		1987		2,560		10			2,560	14
15	Inhouse Labor		1988		7,688		5			7,688	15
16	Shower		1989		3,836	192	20	192		2,781	16
17	Lobby Refurbish/Exterior Renovation		1991		73,428		5			73,428	17
18	Dishwasher and Installation		1991		7,332		10			7,332	18
19	Sidewalk Replacement		1991		4,880		5			4,880	19
20	Remodel		1993		30,862	2,057	15	2,057		21,603	20
21	Vestibule: Wallpaper/Painting; Window Draperies		1996		4,601	307	15	307		2,147	21
22	Combustion Air Handling System		1996		24,969	2,497	10	2,497		17,478	22
23	Fire Alarm System		1996		71,668	7,167	10	7,167		50,168	23
24	Parking Lot Repaving		1997		7,162	477	15	477		2,885	24
25	Roofing: Drain flashing collar; coping replacement;										25
26	deck repair; masonry repointing; install new drains		1997		74,400	4,960	15	4,960		29,967	26
27	Admin offices: carpeting; wallpapering & painting;										27
28	electrical wiring and lighting		1997		12,270	818	15	818		4,942	28
29	Renovate 3 Nursing Floors: painting & wallpapering;										29
30	install ADA handles & mirrors; carpeting & floor										30
31	tiling; installation of glass blocks & window										31
32	masonry; installation & modification of light										32
33	fixtures; plumbing & H.V.A.C. sprinklers		1997		499,653	33,311	15	33,311		201,249	33
34	Security Camera System		1997		16,014	1,601	10	1,601		9,675	34
35	Parking Lot Repaving		1999		8,530	568	15	568		2,559	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Day Room Expansion & Renovation: tear down wall		\$	\$		\$	\$	\$		37
38	between day room & conference room to expand day									38
39	room; install new ceiling & ceiling tiles; new flooring;									39
40	wallpaper & painting; install cupboard & sink; revamp									40
41	closet; window treatment	1999	23,212	2,263	10	2,263		10,183		41
42	Remove & replace all windows on 1st, 2nd, & 3rd floors	1999	118,907	7,927	15	7,927		35,672		42
43	Aquisition and installation of sternberg lights	2000	7,400	493	15	493		1,727		43
44	Fire dampers/automatic closers	2000	21,493	1,433	15	1,433		5,015		44
45	Vonsuperior Panic Hardware for 9 doors	2000	8,058	1,151	7	1,151		4,029		45
46	Demolition of existing entrance, waiting area and									46
47	chapel entrance; install flooring, automatic door system,									47
48	anodized store front thermal glazed window system,									48
49	ceiling tile system w/ lighting, and wall covering;									49
50	relocate chapel entrance; new concrete sidewalks									50
51	and accessibilty ramp.	2000	190,424	19,042	10	19,042		66,648		51
52	Relocate portable fire extinguishers with casing &									52
53	vinyl wallcovering	2001	4,606	921	5	921		2,303		53
54	Acquisition/installation exterior concrete bench	2001	2,674	535	5	535		1,337		54
55	Acquisition/installation 54"X114" plate glass									55
56	for dayroom	2001	1,350	193	7	193		482		56
57	Refinish & apply slip grips 36 bathtubs	2001	9,720	1,944	5	1,944		4,860		57
58	PT/OT renovation: demolition of 2 block walls, casework									58
59	and flooring; install new cabinets; new folding partition;									59
60	new drywall partition; new VCT flooring; paint and vinyl									60
61	wall covering; plumbing for sinks 7 sprinklers	2001	56,042	5,604	10	5,604		14,011		61
62	Parking lot expansion	2002	536,437	34,878	15	34,878		52,316		62
63	Elevator alarm system	2002	30,000	4,286	7	4,286		6,429		63
64	Building security system	2002	21,710	3,101	7	3,101		4,652		64
65	Solar shades/awning & installation	2002	5,084	708	7	708		1,062		65
66	Window air conditioners & installation	2002	10,439	1,930	5	1,930		2,895		66
67	IDPH safety code compliance- includes but not limited to:									67
68	protection of lay-in light fixtures and equipment;									68
69	automatic door closures tied into a fire alarm system which									69
70	TOTAL (lines 4 thru 69)		\$ 4,472,680	\$ 223,260		\$ 223,260	\$	\$ 2,296,918		70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,472,680	\$ 223,260		\$ 223,260		\$ 2,296,918	1
2	is activated by smoke detectors, pull stations and sprinkler								2
3	system; installation of smoke operated fire dampers and								3
4	access panels in exhaust duct system penetrating smoke								4
5	barrier walls located on floors 1,2 and 3.	2002	481,852	46,597	10	46,597		69,895	5
6	Interior renovation-includes but not limited to:								6
7	Toli floor and ramp; carpet administration area; switch-								7
8	bank for lobby and entrance area; new light fixtures in								8
9	various area; replace piping to boilers; new condensing								9
10	unit to north window well; reheat coil in lobby; replace								10
11	bathroom fixtures; replace/upgrade ceiling in various areas;								11
12	various wall modifications; replace various bathroom								12
13	fixtures; various other electrical and plumbing								13
14	modifications.	2002	159,709	16,549	10	16,549		24,824	14
15	Exterior renovation-includes not limited to: sliding doors;								15
16	removal and replacement of concrete curbs; paving, grading								16
17	and stonework; install new fire ceiling and framing in								17
18	smoking area; new handicap signs; various electrical								18
19	work in outside waiting area (including new heaters,								19
20	intercom and doorbell).	2002	98,000	6,533	15	6,533		9,800	20
21	Lobby renovation-includes but not limited to: selective								21
22	demolition of existing lobby, toilet room, and reception								22
23	and replacement of each as well as new assisted bathing,								23
24	this includes new partions, electric plumbing, HVAC,								24
25	accoustic panel ceiling, floor finishes, doors, frames,								25
26	interior windows and casement. Floral fixtures and								26
27	artwork,	2002	166,549	11,732	14	11,732		17,599	27
28	Acquisition/installation of medical records voice and data								28
29	cables, 24-port patch panel, and fire stop & sleeves	2003	6,540	250	13	250		250	29
30	2 sewage pumps	2003	5,752	192	15	192		192	30
31	Down light style fixtures-acquisition and electrical work	2003	3,780	126	15	126		126	31
32	Elevator control valve piping	2003	10,037	502	10	502		502	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,404,899	\$ 305,741		\$ 305,741		\$ 2,420,106	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 773,604	\$ 117,932	\$ 117,932	\$	6.6	\$ 458,450	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	712,742					712,742	73
74								74
75	TOTALS	\$ 1,486,346	\$ 117,932	\$ 117,932	\$		\$ 1,171,192	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,079,666	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 423,673	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 423,673	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,591,298	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 29,287 Description: Copier \$5,183; Kinectic beds \$3,514; generator \$3,688; Infusion/IV pumps \$16,902

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a, Col 1	1509	hrs	\$ 43,704	54	\$ 2,422	\$	1,563	\$ 46,126	1
2	Licensed Speech and Language Development Therapist	10a, Col 1	11	hrs	336	118	5,204		129	5,540	2
3	Licensed Recreational Therapist	11, Col 1	2080	hrs	30,746				2,080	30,746	3
4	Licensed Physical Therapist	10a, Col 1	2072	hrs	61,765	19	840		2,091	62,605	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, Col 2		# of prescrpts				635,233		635,233	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Chargeable supplies	39, Col 2						86,730		86,730	13
14	TOTAL				\$ 136,551	192	\$ 8,465	\$ 721,963	5,864	\$ 866,979	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 193,154	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 713,962)	816,108		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,276		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,016,538	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,421		13
14	Buildings, at Historical Cost	5,403,004		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,488,241		16
17	Accumulated Depreciation (book methods)	(3,591,298)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,488,368	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,504,906	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,853		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses/Due Third Party	47,960		36
37	Due to Affiliates	6,213,107		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,274,920	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,274,920	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,770,014)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,504,906	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (351,828)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (351,828)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(968,708)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (968,708)	17
	B. Transfers (Itemize):		
18	To Affiliates (consolidation of Balance Sheet)	(449,478)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (449,478)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,770,014)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,513,549	1
2	Discounts and Allowances for all Levels	(2,752,696)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,760,853	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,142,352	6
7	Oxygen	22,216	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,164,568	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,426	13
14	Non-Patient Meals	2,453	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	829,167	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,522	19
20	Radiology and X-Ray	10,968	20
21	Other Medical Services	807,869	21
22	Laundry	30,981	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,692,386	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	872	28
28a	Misc. Other	1,674	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,546	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,620,353	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,020,852	31
32	Health Care	2,484,599	32
33	General Administration	1,802,930	33
B. Capital Expense			
34	Ownership	452,960	34
C. Ancillary Expense			
35	Special Cost Centers	759,830	35
36	Provider Participation Fee	67,890	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,589,061	40
41	Income before Income Taxes (line 30 minus line 40)**	(968,708)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (968,708)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **St Francis Nursing & Rehab Center**# **0044370**Report Period Beginning: **07/01/02**

Ending:

06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,424	1,680	\$ 48,635	\$ 28.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,158	36,571	864,321	23.63	3
4	Licensed Practical Nurses	7,952	8,689	149,139	17.16	4
5	Nurse Aides & Orderlies	70,537	76,602	754,061	9.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,865	5,584	137,423	24.61	7
8	Rehab/Therapy Aides	3,949	4,467	56,243	12.59	8
9	Activity Director	1,868	2,080	30,746	14.78	9
10	Activity Assistants	1,323	1,525	12,814	8.40	10
11	Social Service Workers	3,886	4,386	83,205	18.97	11
12	Dietician					12
13	Food Service Supervisor	4,091	4,561	73,583	16.13	13
14	Head Cook	9,222	9,903	94,338	9.53	14
15	Cook Helpers/Assistants	17,244	18,164	124,222	6.84	15
16	Dishwashers					16
17	Maintenance Workers	1,670	1,870	30,878	16.51	17
18	Housekeepers	17,914	19,234	140,302	7.29	18
19	Laundry	1,057	1,135	8,857	7.80	19
20	Administrator	1,856	2,237	96,027	42.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,685	6,156	62,950	10.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,849	2,049	28,363	13.84	31
32	Other Health C: MDS/CarePlan Co	2,252	2,401	61,591	25.65	32
33	Other(specify) <u>Chaplain</u>	1,441	1,543	31,045	20.12	33
34	TOTAL (lines 1 - 33)	193,243	210,837	\$ 2,888,743 *	\$ 13.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	13,128	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,128		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	32	\$ 1,232	Ln 10, Col 3	50
51	Licensed Practical Nurses	8	256	Ln 10, Col 3	51
52	Nurse Aides	156	2,875	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	196	\$ 4,363		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Mellman, Gary	Administrator	0	\$ 79,074	Workers' Compensation Insurance		\$ 20,113	IDPH License Fee		\$		
Soderlind, Dina	Administrator	0	16,953	Unemployment Compensation Insurance		6,411	Advertising: Employee Recruitment				
				FICA Taxes		209,890	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		442,709	Evanston City License		8,040		
				Employee Meals			Marketing & Advertising		0		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		7,965		
				Group Life Insurance		6,205					
				Pension		101,365					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 96,027					
B. Administrative - Other											
Description				Amount			Less: Public Relations Expense		(
				\$			Non-allowable advertising		(0		
							Yellow page advertising		(
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,005		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$			G. Schedule of Travel and Seminar**				
C. Professional Services							Description		Amount		
Vendor/Payee	Type		Amount	Description		Line #	Amount	Out-of-State Travel	\$		
			\$								
								In-State Travel	2,192		
								Seminar Expense	2,058		
								Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$			(agree to Sch. V, line 24, col. 8)		\$ 4,250		

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$3,133
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,192 Line 39
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 67,890
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,453
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at time of filing
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.